

The Board has considered the record and adopted the stipulations listed in the Award, including the August 10, 2004 affidavit of George Hall and the May 20, 2002 report

by SWMC Rehabilitation and Fitness Center. In addition, the Board has considered the transcript of the January 6, 2004 deposition of Karen Clanton.¹

ISSUES

The ALJ found "[t]hat in mid November 2001, he [claimant] had an accident while working." But Judge Fuller further found that claimant "failed to prove that he met with personal injury by accident arising out of and in the course of his employment in November of 2001."² Judge Fuller also found claimant failed to prove he gave respondent timely notice of accident. Based on these latter two findings, the ALJ determined the remaining issues were moot and denied all benefits including temporary total and permanent partial disability compensation. The ALJ also denied claimant's request for reimbursement of \$30.00 in medical expenses and denied future medical treatment.

Claimant contends that he was injured at work sometime around the middle of November 2001, but at the time he did not believe the injury to be such that he needed medical attention. Claimant further argues that he gave timely notice of his accident and that he was off work from January 7, 2002, through July 28, 2002, and is entitled to temporary total disability compensation benefits for that period. Claimant also asserts that he should be awarded a work disability, based upon the average of his 66.23 percent task loss and the difference between his actual pre and post injury gross average weekly wages.

Respondent argues that there is no credible evidence to support claimant's contention that he was injured at work in November 2001 or at any time before his voluntary retirement at the end of December, 2002. Respondent also contends claimant did not give notice of his work-related accident. Respondent requests affirmation of Judge Fuller's August 31, 2004 Award.

The issues before the Board are confined to the issues decided by the ALJ: (1) did claimant meet with personal injury by accident arising out of and in the course of employment and (2) did claimant give timely notice of his work-related accident to respondent as required by K.S.A. 44-520? Should these issues be decided in claimant's favor, the case will be remanded to the ALJ for a determination of the remaining issues.³

¹ Until oral argument before the Board, the parties were not aware that the transcript of the January 6, 2004 deposition of Karen Clanton had not been filed. At that time the parties agreed that it was part of the record and should be considered by the Board in this appeal. Thereafter, the original transcript was located by respondent's counsel and filed with the Division on February 10, 2005.

²Award at 2 (Aug. 31, 2004).

³ Although counsel for claimant was agreeable to the Board deciding the remaining issues without a remand to the ALJ, counsel for respondent was not. See K.S.A. 44-555c(a).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the evidentiary record filed herein, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board concludes that the ALJ's Award should be affirmed. The Board adopts the findings of fact and conclusions of law set forth in the ALJ's Award.

At the time of his alleged accident, claimant had been working for respondent approximately 18 years essentially in the same position of maintenance. His job duties entailed picking up trash, keeping the locker rooms and bathrooms clean, and doing minor repairs as needed.⁴ At the time of the accident claimant was working the 7:00 a.m. to 4:00 p.m. shift.

Claimant testified he did not recall the specific day or even the week but sometime in November 2001, at approximately 10:30 a.m. while carrying a K-50 roto-rooter with a section of cable down a flight of stairs to the women's locker room to roto-rooter a drain line, he slipped and fell down 5 or 6 steps. The roto-rooter weighs 50 to 60 pounds. Claimant said his left leg and left arm and bottom struck the stairs. Claimant testified at the regular hearing that he no longer has any problems with his legs or left arm but continues to experience problems with his back.⁵

Claimant testified he told his immediate supervisor, Tim Mains, about his accident and said he was going over to the nurses' station.⁶ Claimant told the nurse he had just fallen down some stairs and he skinned his leg and arm up and fell on his bottom. Claimant was treated with an ice pack on his left arm along with salve and a band-aid. Claimant testified he did not fill out an accident report nor was there any discussion concerning filling one out. Claimant finished out the workday. At the time, claimant testified his back was not hurting but began to hurt "[a]bout the last week of December, first week of January."⁷ Claimant testified he did not have any other slip and falls nor any other explanation for the onset of his back pain.

Claimant sought medical treatment with his personal physician, Ian F. Yeats, M.D., on January 7, 2002, for the alleged November 2001 injury. Dr. Yeats testified that when claimant presented to him on January 7, 2002, he was complaining of back pain and pain going down the right leg to his foot which Dr. Yeats believed to be acute sciatica. Claimant reported never having the pain before the last two weeks. However, the nurses' chart

⁴Mains Depo. at 5 and 6.

⁵R.H. Trans. at 30 and 31.

⁶*Id.* at 35.

⁷R.H. Trans. at 15.

notes for that day reflect claimant reported complaints “two months with it getting worse in the last two weeks.”⁸ Claimant also had complaints of pain in the shoulder. Dr. Yeats testified that claimant made no mention of any kind of accident. Dr. Yeats’ notes reflect that claimant said the pain just came up over the two weeks before.⁹ Dr. Yeats made a return appointment to assess claimant again.

Claimant returned to Dr. Yeats on January 14, 2002. Claimant reported feeling better. Claimant had been off work for a week. As claimant reported to Dr. Yeats that he had no sick leave Dr. Yeats returned claimant to work at that time. Dr. Yeats said he had no documentation that this was a worker’s compensation case when he gave claimant restrictions. Claimant stated he filled out forms for non-workers’ compensation disability benefits because at the time he filled out the paperwork, January 14, 2002,¹⁰ he did not believe he was hurt and did not think the injury was related to his occupation.¹¹ Claimant did not report this as a work-related injury to Dr. Yeats until February 22, 2002.

Claimant saw Dr. Yeats on January 28, 2002, at which time he ordered a CT scan. The scan revealed no osteoarthritic changes in the anterior aspect of the lumbar spine and no disk herniation. There was no spinal canal stenosis noted. However, there was one metallic fragment that appeared to be embedded in the anterior aspect of the body of L-5 on the left side. But it did not appear to be compromising. Again, there was no mention of claimant injuring himself at work. Dr. Yeats did not make any changes in claimant’s restrictions but claimant said he had been off work because there was no light duty work available. Claimant reported to Dr. Yeats that he had no sick time, but he said:

[T]hey couldn’t find limited work for him. And that’s what happens at National Beef. They will find work if it’s a workmen’s compensation. They will put them on light duties. But, if it’s a person who suffers an injury outside of work, usually, I would say 99 percent of the time, we won’t get work restrictions.¹²

Claimant was seen again on February 8, 2002, with complaints that his back continued to hurt and that he could hardly do anything at home. Dr. Yeats noted again this was not worker’s compensation.

Dr. Yeats saw claimant again on February 22, 2002. Claimant still had complaints of continuous back pain. He was off of work at that time and his wife came with him.

⁸ Yeats Depo. at 21.

⁹ Yeats Depo. at 7.

¹⁰ R. H. Trans. at Resp. Ex. 4.

¹¹ R. H. Trans. at 49 and 50.

¹² *Id.* at 11.

Claimant stated his wife accompanied him to his appointment on February 22, 2002, and his wife informed Dr. Yeats that she believed claimant's back problem was work-related.¹³ Claimant's wife was convinced claimant hurt himself back in November at work when he fell down some steps with the roto-rooter. Dr. Yeats eventually referred claimant to an orthopedic surgeon, Guillermo Garcia, M.D. Claimant was continued on restrictions and told by Dr. Yeats to remain sedentary until he was seen by Dr. Garcia.

Claimant saw Dr. Garcia's physician assistant for the first time March 12, 2002, however, he was not seen by Dr. Garcia personally until March 19, 2002. The initial assessment by the physician's assistant was low back pain with right radiculopathy. Dr. Garcia testified that the physician assistant's notes do not reflect that the low back pain was secondary to a fall, lifting, or twisting. They do, however, reflect that claimant had been having low back pain for a period of about two months before his visit, and that it was slowly getting worse with some variation down the right lower extremity.¹⁴

Dr. Garcia testified that during his physical examination of claimant on March 19, 2002, claimant said that he was continuing to have back pain and that he was not any better. Dr. Garcia's chart note for that date reflects claimant also had complaints of numbness down the right leg to the foot, and that this started two (2) weeks ago.¹⁵ On March 21, 2002, Dr. Garcia reviewed claimant's EMG studies which were consistent with L5-S1 radiculopathy. Dr. Garcia saw claimant again on March 28, 2002, following a myelogram and CT scan which showed that claimant had a herniated disk at L5-S1. Dr. Garcia discussed different alternatives of treatment and claimant elected to have surgery.

On April 22, 2002, Dr. Garcia performed lumbar laminectomy and disk excision surgery of the L5-S1. Claimant was given off-work slips which claimant said he gave to respondent. Claimant was seen by Dr. Garcia's physician assistant for a post-operative visit on May 2, 2002. Stitches were removed and claimant was scheduled to return for a follow-up visit with Dr. Garcia.

On May 16, 2002, Dr. Garcia noted claimant was doing remarkably well and that he had no pain or discomfort in the leg. Claimant reported he was walking about three (3) miles per day and was actively driving. Claimant also completed a course of physical therapy.

On June 13, 2002, Dr. Garcia noted claimant was doing very well and released claimant to return to work on the following Monday, June 17, 2002. Dr. Garcia imposed

¹³*Id.* at 18.

¹⁴ Garcia Depo. at 11.

¹⁵ Garcia Depo. at Ex. 5.

restrictions that claimant needs “to watch limited amount[s] of bending and stooping and his weight lifting should be restricted to 50 pounds.”¹⁶

Claimant saw Dr. Garcia on June 29, 2004 for a disability rating and to determine claimant’s permanent restrictions. At that point, Dr. Garcia believed claimant to be at maximum medical improvement. According to the *Guides*¹⁷ Dr. Garcia opined claimant had a ten (10) percent functional impairment to the body as a whole based on claimant’s laminectomy at L5-S1. Dr. Garcia testified he again imposed restrictions of limited bending and stooping and that claimant’s lifting should be restricted to no more than 50 pounds.

Dr. Garcia did not testify as to causation of claimant’s impairment. Claimant did not indicate to Dr. Garcia that his injury was due to a fall, and/or twisting or lifting at work.¹⁸ But Dr. Garcia testified his file contained records from the physical therapist indicating a work-related accident occurred in November 2001 when he fell down at work while he was carrying a roto-rooter.¹⁹

After Dr. Garcia released claimant back to regular work, claimant returned to the same position with respondent that he had performed before his surgery. Claimant testified he experienced pain in his lower back on a daily basis when he returned to work with respondent. The pain was activity sensitive and increased with bending over or lifting too much or pulling on cable.²⁰ Claimant said he retired from respondent earlier than anticipated as “this injury just helped it along a little bit.”²¹

At the request of respondent’s counsel, claimant was seen by C. Reiff Brown, M.D., on October 22, 2003. Dr. Brown is a board-certified orthopedic surgeon. Based on claimant’s evaluation, review of medical records and claimant’s history and x-rays, Dr. Brown opined:

I can see the cause of some doubt regarding injury as he admits he had no back discomfort whatsoever in December [sic] 2001 when he fell down the stairway. I would have expected had he had a significant injury to his L5-S1 disk subsequently resulting in a herniation that he would have had some low back pain at the time of the injury. However[,] [t]hat is not the case and at times a rather trivial injury will

¹⁶ Garcia Depo. at 18.

¹⁷ American Medical Ass’n, *Guides to the Evaluation of Permanent Impairment* (4th ed.).

¹⁸ Garcia Depo. at 20.

¹⁹ *Id.* at 23.

²⁰ *Id.* at 21.

²¹ *Id.* at 20 and 21.

start the herniation which subsequently becomes symptomatic as much as several weeks later. Most commonly however back pain starts at the time of injury and gradually progresses, the herniation may occur at a later date after the injury has started migration of the nucleus toward the periphery. This man denies any traumatic event other than the fall down the stairs therefore I have to assume that it was that fall that initiated the process of herniation.²²

Thereafter, Dr. Brown imposed permanent restrictions to avoid lifting more than 40 pounds occasionally and 25 pounds frequently. Dr. Brown also stated claimant should “not frequently bend or rotate the lumbar spine greater than 30 degrees.”²³ Using the *Guides*,²⁴ Dr. Brown stated in his letter of May 10, 2004, that claimant fit within DRE Lumbosacral Category III and therefore has a ten (10) percent permanent partial impairment of function to the body as a whole.

At his attorney’s request, claimant was examined by Pedro A. Murati, M.D., on January 21, 2003. Dr. Murati is board-certified as an independent medical examiner. Upon examination claimant reported to Dr. Murati that after his work-related accident he:

[S]tarted to experience immediate low back pain and sustained abrasions to his left forearm. Patient states he reported his injuries to his employer and he was taken to the nurses station. Patient states due to no severe pain complaints; he was released to continue working. Patient states he continued to work performing his regular duties. Patient states his pain complaints increased in severity in his low back and his pain started to radiate down his right leg. Patient states by 12-01 his low back pain became so severe he reported his injuries again. Patients states that nothing was done at that time. Patient states he went on his own to his primary care physician, Dr. Yeast [sic].²⁵

Dr. Murati diagnosed claimant with “[l]ow back pain status post lumbar laminectomy with disc excision at L5-S1.”²⁶ Dr. Murati imposed permanent work restrictions of no lift/carry/push/pull greater than 35 pounds. Occasional bend/crouch/stoop, climb stairs, climb ladders, squat and crawl, can occasionally lift or carry 35 pounds. He can frequently sit, stand, walk and drive, and frequently lift 20 pounds. He can alternate sitting, standing and walking.²⁷ Dr. Murati’s restrictions were based on an eight-hour workday.

²² Brown Depo. at Ex. 1.

²³ *Id.*

²⁴ American Medical Ass’n, *Guides to the Evaluation of Permanent Impairment* (4th ed.).

²⁵ Murati Depo. at Ex. 4 and Murati Depo. at 7..

²⁶ Murati Depo. at Ex. 2.

²⁷ *Id.* at Ex. 2.

Dr. Murati believed claimant's diagnosis was, within a reasonable medical probability, a direct result from the work-related injury that occurred in November 2001 while claimant was employed with respondent. Although Dr. Murati did not testify that claimant was at maximum medical improvement he nonetheless opined, based on the *Guides*, claimant falls into the Lumbosacral DRE Category IV for a 20 percent whole person impairment. Dr. Murati testified that utilizing Jerry Hardin's task list claimant should not perform job tasks nine through 12.²⁸

Tim Mains was claimant's immediate supervisor with respondent. Mr. Mains is a supervisor in the fab maintenance department and has held that position since 1991. In his deposition of October 28, 2003, Mr. Mains testified that the roto-rooter claimant used weighs "12, 15 pounds."²⁹ But on cross examination Mr. Mains testified that the cable weighs 10 to 15 pounds with the cable being maybe 20 feet long. He also testified that claimant did not mention anything to him in November of 2001 regarding an accident with a roto-rooter nor that he had slipped and fell. However, Mr. Mains did testify that the roto-rooter was damaged and that claimant reported this to him stating that the roto-rooter had fallen down the stairs. Mr. Mains could not recall approximately when claimant reported the broken leg of the roto-rooter to him nor did Mr. Mains inquire if claimant was injured as a result of the accident. When asked:

Q. (Mr. Malone) All right. So he came into your office?

A. (Mr. Mains) Yes.

Q. Showed you that there was a broken leg on the K-40 roto-rooter?

A. Yes.

Q. Did he have an explanation of how that occurred?

A. Yeah, he dropped it down the stairs.

Q. All right. Did he tell that [to] you?

A. Yeah.

Q. Did he say anything else?

A. Well, I asked him.

Q. You asked him what happened?

²⁸Murati Depo. at 12-14.

²⁹Mains Depo. at 6.

A. Yeah, what happened?

Q. What did he say?

A. Well, he said [he could] either drop that or hang on to it and fall down the stairs with it.

Q. And what did you understand from that conversation?

A. That he let go of it and it went down the stairs and he did not.³⁰

Mr. Mains did not recall sending claimant to the nurses' station. But Mr. Mains was aware claimant had some physical problems for which he was being treated at the Veteran's Hospital. Mr. Mains was aware that claimant was off work for six (6) months the first part of 2002 but he had been told by claimant's co-worker that this was due to a war injury in the hip.

Heath Clemons is the fab maintenance supervisor and has been employed by respondent for 14 years. Tim Mains is one of the supervisors that works under Mr. Clemons. In his deposition of October 28, 2003, Mr. Clemons testified claimant's work hours were 6:30 a.m. until 3:30 p.m. Mr. Clemons does not remember claimant reporting the work-related injury while he worked under his supervision. Mr. Clemons testified that claimant was going to the VA, locally then to Amarillo, on different occasions. He was aware claimant was off on a leave of absence beginning in January 2002 for a non-work-related accident. Mr. Clemons guessed the roto-rooter claimant carried weighed 60 pounds.

Betty Buchanan is one of the registered nurses that is employed with respondent. She has worked there for 10 and one-half years. She works the B shift which is from 2:00 p.m. to closing which is either 1:00 or 2:00 a.m. In her October 28, 2003 deposition, Ms. Buchanan testified that claimant never reported any work-related accident to her while she was working there. Ms. Buchanan said she never received any accident report on claimant in November 2001 nor did she remember bandaging his arm. The first notice she received regarding claimant's alleged injury was a letter from his attorney dated June 28, 2002. However, there was a registered nurse by the name of Karen Clanton who apparently worked for respondent during the same time frame as claimant. Ms. Buchanan testified that Ms. Clanton "would have worked at 10 a.m. on any date in November of the year 2001."³¹ Claimant testified he thought that the nurses he visited with were Ms. Buchanan and Karen Clanton. He believed Karen was the nurse who applied the salve and that she

³⁰ Mains Depo. at 9 and 10.

³¹ Buchanan Depo. at 23.

said it would be a good idea for claimant to file a claim for workers compensation.³² Ms. Buchanan testified there was no record of any visit by claimant to the nurses' station in November of 2001.

Karen Clanton is a registered nurse that worked for respondent from April 2001 to April of 2002. She worked "A" shift which is from 8:00 a.m. to 4:00 p.m. However, she worked the "B" shift which is from 2:00 p.m. to 10:00 p.m., while in training. Ms. Clanton would have been working the "A" shift in November 2001. Ms. Clanton performed pre-employment physicals, drug urines and random urines. She also took care of injuries that came in, or would go out on the floor and take care of an injury. Ms. Clanton testified respondent's protocol requires nursing staff to fill out a PPE form, which is required for an injury or accident. She is also required to page the safety officer and take care of the injured worker at the same time.

Ms. Clanton testified she read claimant's April 30, 2004 deposition transcript where he indicated Ms. Clanton dressed his arm, put salve on it and bandaged it but she does not have any memory of this incident. Ms. Clanton also testified that no records were kept of individuals picking up Tylenol, band-aids and aspirin. However, if claimant reported an accident there would have been documentation. While Ms. Clanton testified that there is no count taken of band-aids dispensed, they would have documented salve, if it was a cut. If the salve was for an injury at work, a PPE form would be filled out.

Susan Williams has been employed by respondent for six and one-half years as a registered nurse. She arrives at work at 6:00 a.m. and leaves at 2:00 p.m. Ms. Williams testified in her, October 28, 2003 deposition that she has no recollection of claimant coming to the nurses' station to report an accident or a need for treatment. Ms. Williams testified she was off in June for two, two-and-a-half-weeks and in May and possibly in November 2001 for personal illness. She also testified they [the nurses] don't apply ointment. They show the workers where the ointment is and they can apply it themselves. She would not have been involved in the application of any ointment for claimant.

Lupe Martinez is employed by Health and Benefits Systems which is independent from respondent. He has been employed about two and one-half years as the insurance coordinator. In his deposition of January 6, 2004, Mr. Martinez testified that Health and Benefits Systems provides disability benefits for respondent and Mr. Martinez is in charge of that. There are three different types of disability policies; short term, long term and voluntary. Claimant applied for short term disability benefits January 18, 2002. Claimant filled in Part A, Employers Statement, Section 12 on the application as "sickness."³³ However, on the Employees Disability Application, Part B, Section 15, where it asks, Is

³² *Id.* at 26.

³³ Martinez Depo. at Ex. 1.

Claim due to an injury, claimant marked, "yes."³⁴ Under Section 19, State nature of claim, claimant wrote "pinched nerve in lower back."³⁵ Claimant left blank Part A, Section 18, which asked, "Did claim result from job activity?" As to when claimant's symptoms first appeared Mr. Martinez testified claimant wrote "January 9, 2002."³⁶ The disability policy is only for non-work-related injuries. Mr. Martinez also testified that claimant "was paid short term disability and was paid for [the] period 1-8-02 to 3-25-02, a weekly check of one eighty-four seventy. That does include a seven day waiting period so benefits actually began payment on 1-15 of '02."³⁷

Claimant received Social Security benefits commencing in 2003. Claimant also obtained employment with Seward County Council on Aging in February 2003 working 12 to 14 hours weekly. Claimant obtained employment with Meade Lake State Park of Kansas in March 2003 and was paid \$5.30 per hour and worked approximately 24 hours per week. That job continued until October 15, 2003.³⁸ However, the work at Meade Lake State Park of Kansas was seasonal and it does not operate from October through February. Claimant testified he did not work for anyone from January 7, 2002 through July 28, 2002.³⁹

Due to the lack of testimony or other evidence corroborating claimant's version of events, including when the accident was reported and what was said, as well as the length of time that passed between the alleged date of accident and when claimant first sought medical treatment, there being no mention of a work-related accident in the early medical treatment records, the absence of a written accident report, and the fact that claimant did not initially submit his medical bills through workers compensation, but instead used his personal health insurance and applied for short term disability benefits, the Board agrees with Judge Fuller's finding that claimant failed to prove he suffered personal injury by accident at work on the date alleged.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award entered by Administrative Law Judge Pamela J. Fuller dated August 31, 2004, is affirmed.

³⁴ *Id.*

³⁵ *Id.*

³⁶ Martinez Depo. at 12 and Ex. 1.

³⁷ *Id.* at 13 and 17.

³⁸ *Id.* at 21-24.

³⁹ *Id.* at 25-29.

IT IS SO ORDERED.

Dated this _____ day of March 2005.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Randy S. Stalcup, Attorney for Claimant
Terry J. Malone, Attorney for Respondent and Liberty Mutual Insurance Company
Pamela J. Fuller, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director